93-429

No. _____

Supreme Court, U.S.
FILED
SEP 16 1993
OFFICE OF THE CLERK

IN THE

SUPREME COURT OF THE UNITED STATES

OCTOBER TERM, 1993

EPISCOPAL HOSPITAL, ET AL.,

Petitioners,

v.

DONNA E. SHALALA, SECRETARY,
DEPARTMENT OF HEALTH AND HUMAN SERVICES,

Respondent.

ON PETITION FOR WRIT OF CERTIORARI TO THE
UNITED STATES COURT OF APPEALS FOR
THE DISTRICT OF COLUMBIA CIRCUIT

PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE DISTRICT OF COLUMBIA CIRCUIT

Mark H. Gallant
Counsel of Record

Ellen N. Berman

WOLF, BLOCK, SCHORR AND
SOLIS-COHEN
12th Floor, Packard Building
S.E. Corner 15th & Chestnut
Streets
Philadelphia, PA 19102-2678
(215) 977-2000
Attorneys for Petitioners

QUESTION PRESENTED

Whether Congress required the Secretary to apply the adjustment provisions contained in 42 U.S.C. §1395ww(b)(4)(A) in calculating the hospital-specific portion of Medicare reimbursement for the four year transition period under the Prospective Payment System in order to eliminate known distortions in such costs.

TABLE OF CONTENTS

	Page
QUESTION PRESENTED	i
TABLE OF AUTHORITIES	iii
OPINIONS BELOW	1
JURISDICTION	1
STATUTES AND REGULATIONS	2
STATEMENT OF THE CASE	2
A. Introduction	2
B. Statutory and Regulatory Background	3
C. Proceedings Below	6
REASONS FOR GRANTING THE PETITION	10
I. THE DECISION BELOW CREATES A CONFLICT AMONG THE CIRCUITS ON AN IMPORTANT QUESTION OF LAW	10
II. THE DECISION BELOW IS MANIFESTLY INCORRECT: CONGRESS PLAINLY REQUIRED THE SECRETARY TO APPLY THE TEFRA ADJUSTMENTS IN DETERMINING THE HOSPITAL-SPECIFIC PORTION OF MEDICARE REIMBURSEMENT	12
III. THE DECISION BELOW MISAPPLIES CHEVRON AND ITS PROGENY AND ENDORSES A STANDARD OF REVIEW THAT FRUSTRATES CONGRESSIONAL INTENT	17
CONCLUSION	22

TABLE OF AUTHORITIES

Cases	*Page*
Andrus v. Glover Construction Co., 446 U.S. 608 (1980)	14
Board of Governors of the Federal Reserve System v. Dimension Financial Corp., 474 U.S. 361 (1986)	17
Bowen v. Georgetown University Hospital, 488 U.S. 204 (1988)	19
Chevron, U.S.A. Inc. v. Natural Resources Defense Council, Inc., 467 U.S. 837 (1984)	12, 17, 18
Community Hospital of Chandler, Inc. v. Sullivan, 963 F.2d 1206 (9th Cir. 1992)	10, 11, 13, 20
FEC v. Democratic Senatorial Campaign Committee, 454 U.S. 27 (1981)	17
General Care Corp. v. Sullivan, No. 92-1326 (D.D.C.)	11
Georgetown University Hospital v. Bowen, 862 F.2d 323 (D.C. Cir. 1988)	4, 5, 18, 20
Good Samaritan Hospital v. Shalala, ___ U.S. ___, 113 S. Ct. 2151 (1993)	10, 19, 21
Greenville Hospital System v. Bowen, No. 6:85-337-3 (D.S.C. 1986), Medicare & Medicaid Guide (CCH) ¶35,880, *vacated as a condition of settlement*, ¶36,072 (D.S.C. 1986)	11, 19, 20
Hospital Corporation of Tennessee v. Sullivan, No. 92-1325 (D.D.C.)	11
HCA Services of Texas v. Sullivan, No. 92-1324 (D.D.C.)	11
Harmarville Rehabilitation Center, Inc. v. Blue Cross and Blue Shield Association/Blue Cross of Western Pennsylvania, PRRB Hearing Dec. No. 93-D42 (5/20/93), Case No. 85-1135, *reprinted in* Medicare & Medicaid Guide (CCH) ¶41,558	9

	Page
Hillsborough County Hospital Authority, et al., v. Shalala, 91-12-CIV-T-21 (M.D. Fla.)	11
INS v. Cardoza-Fonesca, 480 U.S. 421 (1987)	20
K Mart Corp. v. Cartier, Inc., 486 U.S. 281 (1988)	17
Motor Vehicle Manufacturers Ass'n v. State Farm Auto Ins. Co., 463 U.S. 29 (1983)	19
New York City Health and Hospitals Corp. v. Parales, 954 F.2d 854 (2d Cir.), *cert. denied*, ____ U.S. ____, 113 S. Ct. 461 (1992)	18
Newport Hospital and Clinic, Inc. v. Sullivan, C.A. No. 88-2490-LFO (D.D.C. September 24, 1990), Medicare & Medicaid Guide (CCH) ¶38,844, *Secretary's appeal voluntarily withdrawn* (1991)	11, 13, 20
Nyack Hospital v. Sullivan, No. 92-0455 (D.D.C.)	11
Okeechobee Hospital v. Sullivan, No. 92-1323 (D.D.C.)	11
Redbud Hospital District v. Heckler, No. C-84-4382-MHD (N.D. Cal. 1984), Medicare & Medicaid Guide (CCH) ¶34,085 *vacated on other grounds*, 473 U.S. 1308 (1985)	11
Sacred Heart Medical Center v. Sullivan, 958 F.2d 537 (3d Cir. 1992)	Passim
Securities Industry Ass'n v. Board of Governors of the Federal Reserve System, 468 U.S. 137 (1984)	17, 19
Sunshine Health Systems v. Bowen, 809 F.2d 1390 (9th Cir. 1987)	10, 20
The Methodist Hospital, et al. v. Sullivan, C.A. No. 90-1871-GAG (D.D.C. September 20, 1991), Medicare & Medicaid Guide (CCH) ¶39,627 *appeal pending*, D.C. Cir. Nos. 91-5404 and 92-5034	10, 11, 13
Udall v. Tallman, 380 U.S. 1 (1985)	17
Washington Hospital Center v. Bowen, 795 F.2d 139 (D.C. Cir. 1986)	5, 18

	Page
Statutes	
28 U.S.C. §1254(1)	1
42 U.S.C. §1395d(1)(a)	6
42 U.S.C. §1395q(d)	6
42 U.S.C. §1395x(v)	3
42 U.S.C. §1395ww(a)	1, 13, 14
42 U.S.C. §1395ww(b)	1, 3, 12
42 U.S.C. §1395ww(b)(3)(A)	Passim
42 U.S.C. §1395ww(b)(4)	6
42 U.S.C. §1395ww(b)(4)(A)	Passim
42 U.S.C. §1395ww(b)(6)	6
42 U.S.C. §1395ww(d)(1)	5, 6
42 U.S.C. §1395ww(d)(1)(A)	Passim
42 U.S.C. §1395ww(d)(1)(C)	5
42 U.S.C. §1395ww(d)(5)	15
42 U.S.C. §1395ww(d)(5)(A)-(H)	15
42 U.S.C. §1395ww(d)(5)(E)(i)	6
42 U.S.C. §1395ww(d)(5)(I)	9, 16
42 U.S.C. §1395oo(f)(1)	8
Pub. L. No. 97-248, 96 Stat. 324 (1982)	3
Pub. L. No. 99-272 §9102(b), 100 Stat. 85155 (1986)	5
Pub. L. No. 100-360, 102 Stat. 683 (1988)	9
Regulations	
42 C.F.R. §403.200 *et seq.*	6
42 C.F.R. §405.463	19
42 C.F.R. §405.470(b)(2)(ii) *redesignated* 42 C.F.R. 412.2(b)(2), 412.42(a)	6, 8
42 C.F.R. §409.60	6
42 C.F.R. §409.61	6
42 C.F.R. §409.65(a)	6

	Page
42 C.F.R. §409.68	6
42 C.F.R. §412.2	1, 6
42 C.F.R. §412.2(b)(2)	7
42 C.F.R. §412.42(a)	7
42 C.F.R. §412.70	1
42 C.F.R. §412.71	1, 20
42 C.F.R. §412.71(a)	6
42 C.F.R. §412.71(b)(5), (6), (7) *formerly* 42 C.F.R. 405.474(b)(2)	8
42 C.F.R. §412.71(c)(1)(ii)	8
42 C.F.R. §412.71(d)	8
42 C.F.R. §412.72	1, 20
42 C.F.R. §412.72(a)	8
42 C.F.R. §412.73	1
42 C.F.R. §412.73(a)	6
42 C.F.R. §413.40	3, 19
42 C.F.R. §413.40(f)-(g)	4

Federal Register

57 Fed. Reg. 23660 (June 4, 1992)	10
53 Fed. Reg. 38520 (Sept. 30, 1988)	9
51 Fed. Reg. 8208, 8210 (Mar. 10, 1986)	19
49 Fed. Reg. 279 (Jan. 3, 1984)	6
49 Fed. Reg. 261 (Jan. 3, 1984)	5, 19
48 Fed. Reg. 39752, 39818 (Sept. 1, 1983)	6

Legislative History

H.R. 1900, Rep. No. 98-25, Part 1, 98th Cong. 1st Sess.	15
H.R. Conf. Rep. No. 98-47, 98th Cong. 1st Sess. 182, *reprinted in* 1983 U.S.C.C.A.N. 404, 471-72	5, 15
H.R. Rep. No. 100-105, 100th Cong., 2d Sess., *reprinted in* 1988 U.S.C.C.A.N. 803, 813	9

Page

H.R. Rep. No. 98-25, 98th Cong., 1st Sess. 132, 136, *reprinted in* 1983 U.S.C.C.A.N. 355 ..... 4, 5, 15

S. Rep. No. 98-23, 98th Cong., 1st Sess. 49-50, 53, *reprinted in* 1983 U.S.C.C.A.N. 143, 189-90, 193 5, 6

IN THE

SUPREME COURT OF THE UNITED STATES

OCTOBER TERM, 1993

No. _____

EPISCOPAL HOSPITAL, ET AL.,

Petitioners,

v.

DONNA E. SHALALA, SECRETARY,
DEPARTMENT OF HEALTH AND HUMAN SERVICES,

Respondent.

PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE DISTRICT OF COLUMBIA CIRCUIT

Episcopal Hospital, et al. ("petitioners") respectfully petition for a writ of certiorari to review the judgment of the United States Court of Appeals for the District of Columbia Circuit in this case.

OPINIONS BELOW

The opinion of the Court of Appeals (Appendix 1a)[1], is reported at 994 F.2d 879 (D.C. Cir. 1993) (Sentelle, C.J.). The opinion and orders of the District Court (App. 11a) are unreported. The opinions of the Provider Reimbursement Review Board ("PRRB") (App. 28a, 31a, 34a), are unreported.

JURISDICTION

The judgment of the Court of Appeals was entered on June 18, 1993 (App. 10a). The jurisdiction of the Court is invoked under 28 U.S.C. 1254(1).

---

1 Pages in the Appendix are cited as "App. a."

STATUTES AND REGULATIONS[1]

The following statutes and regulations are set forth in the Appendix to the Petition:

42 U.S.C. §1395ww(a)	42 C.F.R. §412.70
42 U.S.C. §1395ww(b)	42 C.F.R. §412.71
42 U.S.C. §1395ww(d)	42 C.F.R. §412.72
42 C.F.R. §412.2	42 C.F.R. §412.73

STATEMENT OF THE CASE

A. Introduction

Petitioners are seven non-profit Philadelphia area hospitals.[2] They challenge the refusal of the Secretary of Health and Human Services ("HHS") to adjust the allowable base-year costs used to calculate the "hospital-specific portion" (or "HSP") of their Medicare rates throughout the four-year "transition period" leading to payments based on a fully federal rate under the Prospective Payment System ("PPS"). Congress mandated a transition period, during which each participating hospital's payment rates are based in substantial part on its own costs incurred during a pre-PPS "base year." The purpose of the transition period was to minimize financial disruption resulting from a change to PPS from the prior reimbursement system, under which hospitals had for two decades been retrospectively reimbursed Medicare's share of the costs they actually incurred. Petitioners specifically sought upward adjustments of their base-year operating costs to account for certain Medicare coverage changes initiated after the base-year, which rendered their hospital-specific base payment amounts non-comparable with operating costs during the transition period.

---

2. *Rule 29.1 Statement:* Parties to the action include: Episcopal Hospital (no parent company; subsidiaries include Episcopal Heart Institute, Episcopal Billing Corporation and Episcopal Cardiovascular Corporation), Presbyterian-University of Pennsylvania Medical Center (no parent company; no subsidiaries), Thomas Jefferson University Hospital (no parent company; no subsidiaries), The Graduate Hospital (parent company Graduate Health System; no subsidiaries), Mercy Catholic Medical Center (parent company Mercy Health Corporation has two divisions: Fitzgerald Mercy Hospital and Misericordia Hospital; no subsidiaries), Medical College of Pennsylvania (parent company Allegheny Health, Education and Research Foundation; no subsidiaries), Metropolitan Hospital (no parent company; no subsidiaries).

The refusal to adjust the base-year costs in formulating the hospital-specific rates runs afoul of the statute and legislative history, embodies an about face by the Secretary concerning the availability of such adjustments in determining the PPS hospital-specific rates with far reaching implications, and has deprived petitioners of approximately two million dollars of reimbursement for care rendered to Medicare recipients. In upholding the Secretary's restrictive approach, the lower court has aligned itself with the Third Circuit in direct conflict with two prior decisions of the Ninth Circuit and a uniform body of district court decisions. These factors warrant a definitive ruling by this Court.

B. Statutory and Regulatory Background

The Medicare Program established by Title XVIII of the Social Security Act, 42 U.S.C. §1395 *et seq.*, pays for covered medical services provided to eligible aged and disabled persons. It encompasses inpatient hospital insurance coverage, under "Part A," and supplemental medical insurance coverage (for physicians' services, tests and other ancillary services), under "Part B." This case involves petitioners' reimbursement under Part A.

Prior to October of 1983 hospitals were reimbursed by Medicare retrospectively, based upon each hospital's allowable costs, under a "reasonable cost reimbursement system." 42 U.S.C. §1395x(v). In 1982, Congress, enacting the Tax Equity and Fiscal Responsibility Act ("TEFRA"), modified somewhat the payment regime to contain Medicare costs. Pub. L. No. 97-248, 96 Stat. 324 (1982), *codified in part* in 42 U.S.C. §1396ww(b). While TEFRA left the basic retrospective, cost-reimbursement structure of Part A intact, it tied each hospital's annual rate of payment increase to a "target amount," defined in 42 U.S.C. §1395ww(b)(3)(A) (1988) as the hospital's allowable costs of inpatient hospital services for the preceding cost reporting period (or base-year), increased by a specified percentage in each succeeding cost reporting period. Hospitals with costs exceeding the prescribed rate-of-increase above the base-year target amounts were subject to a penalty. 42 U.S.C. §1395ww(b)(1)(A); 42 C.F.R. §413.40 (1992).

In establishing this framework, Congress recognized that coverage changes and other disparities might affect the essential comparability of allowable costs incurred during and after the TEFRA base-year. TEFRA accordingly directs the Secretary to provide

for exemptions from and exceptions and adjustments to the TEFRA payment amount "where events beyond the hospital's control or extraordinary circumstances, . . . create a distortion in the increase in costs for a cost reporting period . . ." 42 U.S.C. §1395ww(b)(4)(A).[3] As part and parcel of this target amount formulation, a conforming regulatory mechanism was implemented for adjusting the hospital-specific base-year costs to maintain comparability of allowable operating costs before and after the base-year. 42 C.F.R. §413.40(f)-(g).

In 1983 Congress supplanted this payment system as to most general hospitals with PPS.[4] Under PPS, payments for operating costs — the largest portion of Part A reimbursement — are set in advance based on a standardized per admission rate which is multiplied by a weighing factor depending on the diagnosis related group ("DRG") into which the admission falls. *See Georgetown University Hospital v. Bowen*, 862 F.2d 323, 324 (D.C. Cir. 1988). This "radically new" system was "designed to reform the financial incentives hospitals face" by "promoting efficiency." *Id.* at 324, *quoting* H.R. Rep. No. 98-25, 98th Cong., 1st Sess. 132, *reprinted in* 1983 U.S.C.C.A.N. 143, 219, 315. At the same time, "Congress recognized that implementation of the new PPS threatened severe financial dislocations in the health care delivery system." *Id.* To "minimize disruption that might otherwise occur because of sudden change," Congress, over the Secretary's objection, included a three-year transition period, later extended to four years, during which a hospital's prospective payment would be based on an increasing federal portion, unrelated to individual

---

3. 42 U.S.C. §1395ww(b)(4)(A) states more fully:

> The Secretary shall provide for an exemption from or an exception and adjustment to, the method under this subsection [1395ww(b)] for determining the amount of payment to a hospital where events beyond the hospital's control or extraordinary circumstances, including changes in the case mix of such hospital, create a distortion in the increase in costs for a cost reporting period (including any distortion in the costs for the base period against which such increase is measured)* * *

4. The TEFRA cost limit system continues to govern inpatient hospital reimbursement for hospitals and hospital units that are exempt from PPS, e.g., psychiatric and rehabilitation hospitals.

hospital costs, and a hospital-specific portion (or "HSP").[5] *Id.*, *quoting* S. Rep. No. 98-23, 98th Cong., 1st Sess. 53, *reprinted in* 1983 U.S.C.C.A.N. 143, 193; *Washington Hospital Center v. Bowen*, 795 F.2d 139, 142 (D.C. Cir. 1986).

In 42 U.S.C. §1395ww(d)(1), Congress directed the Secretary to use each hospital's TEFRA "target amount," as defined in §1395ww(b)(3)(A), in calculating the HSP. This amount uses allowable operating costs of inpatient services during the preceding 12-month cost reporting period. 42 U.S.C. §1395ww(b)(3)(A); *Georgetown*, 862 F.2d at 324. It was to be adjusted for inflation and otherwise updated during the transition period. §1395ww(d)(1).

The HSP component of the DRG rate serves as a proxy for reimbursable costs incurred by particular hospitals, but of necessity, had to be constructed in advance of the transition period. As noted above, §1395ww(b)(4)(A) provides for mandatory adjustments of base-year costs in advance of setting the target amount in order to neutralize documented disparities in allowable operating costs during and following the relevant base-year which are attributable to events beyond a hospital's control or extraordinary circumstances. In the preamble to the final regulations implementing PPS, the Secretary acknowledged expressly that §1395ww(b)(4)(A) was incorporated into the HSP-setting process so that the HSP will, as closely as practicable, be representative of allowable hospital-specific costs going forward. 49 Fed. Reg. at 261 (Jan. 3, 1984). Additionally, in enacting PPS the Conference Committee directed the Secretary to "use estimates to adjust some portions of the hospital's base year experience to make it comparable to inpatient operating costs that will be paid under the prospective system — e.g., FICA taxes that would have been paid if the hospital had been in the social security system . . . ." H.R. Conf. Rep. No. 98-47, 98th Cong., 1st Sess. 181-82, *reprinted in* 1983 U.S.C.C.A.N. 404, 471-72.[6]

5. The HSP controls reimbursement to a significant degree over the course of the transition period, gradually declining from 75% of the total DRG rate until the blended rate is replaced by a fully federal rate in the fifth year of PPS. 42 U.S.C. §1395ww(d)(1)(C), *as amended* by Pub. L. No. 99-272 §9102(b), 100 Stat. 85155 (1986).

6. The Senate Committee similarly recognized that certain services covered by Medicare Part A under PPS were not covered as allowable costs during the base-year, and that various "exceptions and adjustments" were required to take such

C. Proceedings Below

In general terms, the HSP is derived by dividing a numerator, consisting of total "allowable" operating costs for Medicare patients — i.e., those costs reimbursable under Part A — in the base-year, by a denominator consisting of the total number of Medicare patients "discharged" during the base-year, to yield a base per-discharge cost. 42 U.S.C. §1395ww(b)(4) and (d)(1); 42 C.F.R. §§412.2, 412.71(a), 412.73(a). Before and after PPS, Medicare beneficiaries were "covered" for 90 days of Part A hospital inpatient services annually per "spell of illness." 42 U.S.C. §1395d(1)(a); 42 C.F.R. §§409.60, 409.61. Under cost-based reimbursement, hospitals received reimbursement for allowable operating costs of services provided to Medicare patients only to the extent the services were provided on days for which the patients had Medicare coverage. 42 U.S.C. §1395q(d). If coverage expired after at least one covered day of a hospital stay hospitals were entitled to directly bill the patients or their private "Medigap" insurers for the additional amounts due for any days of hospitalization following the exhaustion of Medicare coverage. 42 C.F.R. §§409.61, 409.65(a), 409.68; 49 Fed. Reg. 279 (Jan. 3, 1984); 42 C.F.R. 403.200 *et seq.* In implementing PPS, the Secretary modified the Medicare coverage rules by discretionary regulation so that, henceforth, the entirety of any inpatient hospital stay involving at least one day of Medicare eligibility would be treated as a fully "covered" stay under Part A, for which the PPS payment itself would necessarily represent payment in full.[7]

---

situations into account because "the prospective payment is intended to be payment in full for all covered items and non-physician services to hospital inpatients." S. Rep. No. 98-23, 98th Cong., 1st Sess. 49-50, *reprinted in* 1983 U.S.C.C.A.N. 189-190. Adjustments for some disparities, which were clearly anticipated by Congress in advance, were specifically delineated. *See, e.g.*, 42 U.S.C. §1395ww(b)(6) (FICA taxes which were added after the base-year due to "bundling" of usage-costs of employed hospital staff who fomerly billed separately and outside the scope of Part A); §1395ww(d)(5)(E)(i) (adjustments for ancillary hospital services previously covered under Part B of Medicare). Other such "distortion" causing events and Part A coverage changes were not identified by Congress specifically, but were nevertheless anticipated categorically and categorically made subject to a mandatory adjustment through the incorporation of §1395ww(b)(4)(A).

7. 42 C.F.R. §405.470(b)(2)(ii)(1984), 48 Fed. Reg. 39752, 39818 (Sept. 1, 1983), *redesignated* 42 C.F.R. §§412.2(b)(2), 412.42(a).

Consequently, operating costs that were not recognized in the base year, solely because they were incurred after the exhaustion of Medicare coverage during an initially covered stay, were not taken into account in determining the HSP.[8] Because the costs of such stays would henceforth be deemed allowable costs and solely and exclusively reimbursed by DRG payments, 42 C.F.R. §§412.2(b)(2) and 412.42(a), petitioners timely requested adjustments of their HSPs to prevent the loss of reimbursement for these hospital-specific costs throughout the course of the transition period. Relying on actual filed cost-report data, and prior to the start-up of PPS, each petitioner identified otherwise reimbursable base-year costs (ranging from approximately $41,000 to $355,000) attributable to and excluded solely because they attached to post-coverage exhaustion days of initially covered stays, and requested its fiscal intermediary to adjust its average per discharge base year costs to take its "lost" costs into account in calculating the HSP.[9] Petitioners assumed *inter alia* that the TEFRA adjustment provisions contained in 42 U.S.C. §1395ww(b)(4)(A) had been incorporated into PPS along with §1395ww(b)(3)(A) and mandated this adjustment. Each petitioner's request was premised on the notion that the PPS-Medicare policy change for "exhausted coverage" days and the resulting exclusion of such operating costs from the base-year HSP calculation constituted an event beyond the hospital's control which produced a "distortion" between allowable costs in the base-period and the PPS transition years requiring an adjustment.

There was no factual dispute concerning the scope or the bona fides of the additional costs that would be subject to recognition under subsection (b)(4)(A). The intermediaries, however, denied the requests on the basis that the amounts in question were not considered "allowable operating cost[s] of inpatient services" during the base-year, and that an adjustment to eliminate this disparity was not among the "modifications" specifically delineated in

---

8. The exclusion of these costs reduced the "numerator" (i.e., total Medicare costs) referenced on p. 6 without affecting the denominator (i.e., total number of Medicare patients), thereby diluting the resulting target amount.

9. It is not necessarily the case that this particular disparity — which tends to occur for certain types of lengthy admissions, such as burn cases — occurs for all hospitals.

"current regulations," *i.e.*, "Section 405.474(b) [*redesignated* 412.71(b)]," a position confirmed by HHS.[10]

Petitioners filed "group appeals" before the Provider Reimbursement Review Board ("PRRB") for all transition years. (App. 28a, 31a, 34a) Pursuant to 42 U.S.C. 1395oo(f)(1), these were certified for "expedited judicial review" to the District Court because there were no disputed issues of fact, the PRRB is bound by Medicare regulations, and the pertinent regulations did not authorize the PRRB to grant the requested adjustments. (App. 28a, 31a, 34a) On review, the District Court awarded summary judgment to the Secretary, and the Court of Appeals for the District of Columbia Circuit affirmed.

The Court of Appeals held that the TEFRA provision requiring adjustments to the base-year where "events beyond a hospital's control" or "extraordinary circumstances" create a distortion in the increase in costs for a cost reporting period, 42 U.S.C. §1395ww(b)(4)(A), was only applicable to adjusting a hospital's target amount for TEFRA purposes and had not been incorporated into PPS. This determination was grounded in the Court's view that Congress did not incorporate the mandatory base-year adjustment provisions (for eliminating distortions beyond the hospital's control) of subsection (b)(4)(A) because the PPS provision, subsection (d)(1)(A), explicitly mentions only subsection (b)(3)(A). As a result, the Court held that the Secretary was not required to make the requested adjustments, and that the decision not to provide for adjustments to eliminate distortions between pre and post base-year operating costs was discretionary and enti-

---

10. In implementing PPS, the Secretary adopted regulations which gave to fiscal intermediaries responsible for setting the HSP extremely broad authority to "exclude" base-year costs which might improperly inflate the hospital-specific portion under PPS. 42 C.F.R. §§412.71 (b)(5), (6), (7) *formerly* 42 C.F.R. §405.474(b)(2)). In contrast, however, the Secretary more narrowly and presumptively limited the fiscal intermediaries' authority to increase base-year cost estimates in setting the HSP. Aside from being told to correct for ministerial and mathematical errors, 42 C.F.R. §412.72(a), intermediaries were instructed in formulating the HSP to use the best data available at the time in estimating each hospital's base-year costs and to allow modifications only to account for limited adjustments extending to the two specific examples of cost mismatches (FICA taxes, and certain costs reimbursed under Part B, which were not reimbursed under Part A in the base-year). 42 C.F.R. §412.71 (c)(1)(ii); §412.71(d) (*formerly* 42 C.F.R. §405.474(b)(2)(ii) and (iii)).

tled to deference.[11] Without addressing the Conference Report, or the prevailing contrary judicial authority, the Court concluded that adjustments to hospital-specific costs under PPS were limited to circumstances covered by discretionary adjustments recognized by the Secretary under regulations adopted pursuant to 42 U.S.C. §1395ww(d)(5)(I).

---

11. The District Court assumed that 42 U.S.C. §1395ww(b)(4)(A) required the Secretary to adjust base-year costs under PPS "where events beyond the hospital's control" produce a "distortion" between allowable cost in the base-period and the PPS transition years, but concluded that a coverage change effected by the Secretary was not within the ambit of events contemplated by the statute. Having dispositively ruled as a threshold matter that subsection (b)(4)(A) was not incorporated into PPS, the Court of Appeals did not address this issue. There is however little doubt that adjustments based on regulatory changes which expand Medicare coverage after the relevant base-year fall precisely within the class of extraordinary circumstances to which §1395ww(b)(4)(A) was addressed. Thus, under the Medicare Catastrophic Coverage Act of 1988 ("MCCA"), Pub. L. No. 100-360, 102 Stat. 683 (1988) (which was repealed after a brief period), Congress expanded Medicare coverage by eliminating the annual spell of illness and life time reserve days referenced above, and substituted unlimited days of coverage. In light of the expansion of Medicare coverage and the corresponding reduction in direct beneficiary and Medigap payments to hospitals, Congress instructed the Secretary expressly to adjust the TEFRA hospital-specific target rates to take into account any reduction in Medicare Part A payments to hospitals resulting from the elimination of the day limitation on Medicare coverage of inpatient hospital services. H.R. Rep. No. 100-105(I), 100th Cong., 2d Sess., *reprinted in* 1988 U.S.C.C.A.N. 803, 814. In adopting regulations under MCCA, the Secretary recognized the need under TEFRA to make "the *adjustment* . . . *available* to *any* hospital that *experiences a distortion* due to increased costs caused by the elimination of the inpatient entitlement limitation . . . . This is because any distortion will be due to the effect of . . . [*the change in law*] and essentially is unrelated to the actions of any individual hospital." 53 Fed. Reg. at 38520-21 (Sept. 30, 1988) (emphasis added). More recently, in *Harmarville Rehabilitation Center, Inc. v. Blue Cross and Blue Shield Association/Blue Cross of Western Pennsylvania*, PRRB Hearing Dec. No. 93-D42 (5/20/93), Case No. 85-1135, *reprinted in* Medicare & Medicaid Guide (CCH) ¶41,558, the PRRB held that an insurer's elective change in Medigap supplemental payment policies, which shifted the portion of inpatient costs paid previously by Medigap supplemental policies to the Medicare program, caused a significant distortion in the provider's Medicare inpatient operating costs for the base period and/or the first rate year which was beyond the provider's control and mandated a TEFRA adjustment under subsection (b)(4)(A). In so holding, the PRRB relied on the MCCA as clearly evidencing Congress' intention that post-base-year Medicare coverage expansions attributable to coverage changes imposed upon hospitals by third-party insurers (including direct coverage changes under Medicare or indirect Medicare coverage expansions resulting from reductions in discretionary cover-

REASONS FOR GRANTING THE PETITION

I. THE DECISION BELOW CREATES A CONFLICT AMONG THE CIRCUITS ON AN IMPORTANT QUESTION OF LAW

This case raises the important question of whether the TEFRA target amount adjustment provisions contained in 42 U.S.C. §1395ww(b)(4)(A) were incorporated into PPS, concerning which there is a clear cut split among the circuits. This issue potentially impacts all hospitals which experienced and were able to document significant changes in otherwise allowable operating costs occurring after their base-years but prior to the start date of PPS.[12] Among other things, this issue is controlling of whether the HSP is subject to adjustment in the case of hospitals that completed significant construction and experienced related changes in services after the base-year (factually, the scenario involved in the *Sacred Heart*, *Chandler* and *Methodist* cases *infra*). The failure to recognize adjustments designed to eliminate such distortions and attain comparability between the pre and post base-year operating costs of hospitals undermines the use of the HSP as a valid proxy of a given hospital's true costs throughout the extended transition period, and vitiates the buffer which Congress sought to impose against the "disruptions" and "severe financial dislocations" by tying a significant portion of hospitals' DRG payment rates on individualized, hospital-specific costs.

In two separate cases, *Community Hospital of Chandler, Inc. v. Sullivan*, 963 F.2d 1206 (9th Cir. 1992), and *Sunshine Health Systems v. Bowen*, 809 F.2d 1390 (9th Cir. 1987), the Ninth Circuit held that Congress clearly intended to incorporate §1395ww(b)(4)(A) into PPS. Numerous district courts which have addressed the issue have uniformly concluded that Congress intended subparagraph (b)(4)(A) to be incorporated into

---

age by "gap" insurers) are events requiring adjustments under §1395ww(b)(4)(A). Any doubt about this point is removed by the Secretary's proposed rule "clarifying" the TEFRA ceiling adjustment regulations specifically to reach such coverage changes. 57 Fed. Reg. 23660 (June 4, 1992). Accord 57 Fed. Reg. 39746, 39803 (Sept. 1, 1992 final rule).

12. Last term, in *Good Samaritan Hospital v. Shalala*, ___ U.S. ___, 113 S.Ct. 2151 (1993), this Court explored the reach and operation of a distinct but complementary set of Medicare cost limit rules that applied to pending cases still subject to the former reasonable cost reimbursement system.

(b)(3)(A) for PPS purposes.[13] By contrast, the Third Circuit in *Sacred Heart Medical Center v. Sullivan*, 958 F.2d 537 (3d Cir. 1992), *reversing* 1991 U.S. Dist. LEXIS 9535 (E.D. Pa. 1991), like the court below, acquiesced in the Secretary's (current) approach that target amounts are not subject to adjustments pursuant to §1395ww(b)(4)(A) for purposes of PPS.

Five separate cases turning on this issue are currently pending in the District Court for the District of Columbia.[14] Another such pending case, *Hillsborough County Hospital Authority, et al., v. Shalala*, 91-12-CIV-T-21 (M.D. Fla.) involves adjustment claims of 114 individual hospitals. Similarly, in *The Methodist Hospital, et al., v. Shalala*, Nos. 91-5405 and 92-5034 (D.C. Cir. 1993), the Court of Appeals for the District of Columbia Circuit recently removed from the argument calendar a series of consolidated cases that turn on whether the TEFRA adjustment provision was incorporated by PPS, apparently because the panel's decision below is controlling of all such cases.[15] The number of cases which have been brought by hospitals seeking similar adjustments to their HSP rates further underscores the need for a unified resolu-

13. The Ninth Circuit in *Chandler* noted with approval that numerous District Courts that have addressed this issue have similarly concluded that Congress intended subparagraph (b)(4)(A) to be incorporated into subparagraph (b)(3)(A) for PPS purposes. *See, The Methodist Hospital, et al. v. Sullivan*, C.A. No. 90-1871-GAG (D.D.C. September 20, 1991), Medicare & Medicaid Guide (CCH) ¶39,627, *appeal pending*, D.C. Cir. Nos. 91-5404 and 92-5034; *Newport Hospital and Clinic, Inc. v. Sullivan*, C.A. No. 88-2490-LFO (D.D.C. September 24, 1990) Medicare & Medicaid Guide (CCH) ¶38,844, *Secretary's appeal voluntarily withdrawn* (1991); *see also Greenville Hospital System v. Bowen*, No. 6:85-337-3 (D.S.C. 1986), Medicare & Medicaid Guide (CCH) ¶35,880, *vacated as a condition of settlement, Id.* ¶36,072 (D.S.C. 1986); *Redbud Hospital District v. Heckler*, No. C-84-4382-MHD (N.D. Cal. 1984), Medicare & Medicaid Guide (CCH) ¶34,085, *vacated on other grounds*, 473 U.S. 1308. Prior to the opinion below, the sole contrary decision was issued by the Third Circuit in *Sacred Heart Medical Center v. Sullivan*, 958 F.2d 537 (3d Cir. 1992), *reversing* 1991 U.S. Dist. LEXIS 9535 (E.D. Pa. 1991). This body of law was not even alluded to by the Court below, which recently denied a request for initial hearing en banc in *The Methodist Hospital* case.

14. *Nyack Hospital v. Sullivan*, No. 92-0455; *Okeechobee Hospital v. Sullivan*, No. 92-1323; *HCA Services of Texas v. Sullivan*, No. 92-1324; *Hospital Corporation of Tennessee v. Sullivan*, No. 92-1325; *General Care Corp. v. Sullivan*, No. 92-1326.

15. Petitioners are not able to ascertain precisely how many additional cases turning on this issue are pending before the PRRB.

tion to the question of whether the TEFRA adjustments were incorporated into PPS.

II. THE DECISION BELOW IS MANIFESTLY INCORRECT: CONGRESS PLAINLY REQUIRED THE SECRETARY TO APPLY THE TEFRA ADJUSTMENTS IN DETERMINING THE HOSPITAL-SPECIFIC PORTION OF MEDICARE REIMBURSEMENT

Congress clearly intended the TEFRA adjustments — which are an integral part of setting the TEFRA target amount — to be incorporated into PPS. "If the intent of Congress is clear, that is the end of the matter; for the court, as well as the agency, must give effect to the unambiguously expressed intent of Congress." *Chevron, U.S.A. Inc. v. Natural Resources Defense Council, Inc.*, 467 U.S. 837, 842-43 (1984). Moreover, "[t]he judiciary is the final authority on issues of statutory construction and must reject administrative constructions which are contrary to clear Congressional intent." *Id.* at 843 n.9. The lower court's determination that the PPS statute did not incorporate the TEFRA adjustments is based on an incomplete and superficial reading of the Act.

42 U.S.C. §1395ww(d)(1)(A) provides that during the PPS transition period, the payment for inpatient hospital services is determined by blending the federal DRG and the hospital's TEFRA "target amount . . . as defined in subsection [1395ww](b)(3)(A)." Target amounts under subsection (b)(3)(A) are, in turn, expressly and integrally subject to exceptions and adjustments provided under §1395ww(b)(4)(A), which states that:

> The Secretary shall provide for an exemption from, or an exception and adjustment to, the method *under this subsection* [1395ww(b)] for determining the amount of payment to a hospital where events beyond the hospital's control or extraordinary circumstances, including changes in the case mix of such hospital, create a distortion in the increase in costs for a cost reporting period (including any distortion in the cost of the base period against which such increase is measured). (Emphasis added.)

Importantly, this disputed subparagraph refers to the method for determining the target amount "under this subsection", *i.e.*, §1395ww(b), which includes subparagraph (b)(3)(A). The PPS

provisions (§1395ww(d)(1)(A)) cross-reference and incorporate by express reference the TEFRA target amount determined under §1395ww(b)(3)(A), which is extricably linked under the TEFRA provisions to subsection (b)(4)(A).[16]

This interpretation was expressly upheld by the Ninth Circuit, which concluded that the reference to §1395ww(b)(3)(A) in §1395ww(d)(1)(A) was clearly intended by Congress to incorporate §1395ww(b)(4)(A). In *Chandler*, *supra*, the Court held that the Secretary was required to take into account additional costs incurred as a result of the construction of a new facility after the base year, but prior to the onset of PPS, stating:

> [W]e find that *Congress did intend to incorporate §1395ww(b)(4)(A)* [into §1395ww(d)]. As we have noted before, "although the PPS is basically embodied within 42 U.S.C. §1395ww(d) . . . there is clear interface between 1395ww subsections (b) and (d)." *Sunshine Health*, 809 F.2d at 1398 . . . . Thus, in light of the fact that §1395ww(d) "by its own terms incorporates one of the main concepts of subsection (b)," we found it illogical to exclude from PPS other subsections of §1395ww(b). *Id.*

Chandler, 963 F.2d at 1214 n.4 (emphasis added).[17]

Incorporation of the TEFRA adjustment into PPS is also compelled by negative inference, as other courts have recognized, *see Methodist*, *id.* (Gesell, D.J.). Thus, §1395ww(d)(1)(A) states that the PPS target amount is to be determined under §1395ww(b)(3)(A) but "without the application of subsection (a) of this section [§1395ww(a)] . . . ." If, as the lower court incorrectly held, the incorporation of the TEFRA target provisions were strictly limited to subsection (b)(3)(A) itself, so as to facially

---

16. As Judge Oberdorfer stated in rejecting the Secretary's contention that Congress did not mean to incorporate subparagraph (b)(4)(A) in *Newport*, *supra*:

> This contention has no merit. Subsection (b)(3)(A) defines "target amount" as the allowable costs as set forth in yet another subsection. Subsection (b)(4)(A) establishes exceptions to subsection (b), including (b)(3)(A). For this reason, subsection (b)(3)(A) cannot be cleanly extracted from its statutory environment even if Congress neglected to refer to (b)(4)(A) explicitly [in section (d)(1)(A)].

Medicare & Medicaid Guide (CCH) ¶38,844 at 24,063. *Accord Methodist*, *supra*, Medicare & Medicaid Guide (CCH) ¶39,627 at 28,117.

17. The Ninth Circuit expressly disagreed with the contrary view adopted by the Third Circuit. *Id.*

exclude consideration of (b)(4)(A), there would have been absolutely no reason for Congress to prescribe, in §1395ww(d)(1)(A), the incorporation of the TEFRA target amount determined pursuant to (b)(3)(A) "without the application of subsection (a) of this section [§1395ww]." Rather, it is clear that Congress intended to incorporate fully the target rate-setting mechanism of TEFRA, including the critically important, mandatory provisions of subsection (b)(4)(A) for neutralizing distorting differences in allowable base-year and post base-year costs, with the limited exception of the percentage limitations separately provided for under subsection (a). This was the only limitation imposed.

The act of expressly excluding one subsection raises an inference that the other subsections are not to be excluded. "[W]here Congress explicitly enumerates certain exceptions to a general prohibition, additional exceptions are not to be implied in the absence of evidence of a contrary legislative intent." *Andrus v. Glover Construction Co.*, 446 U.S. 608, 616, 617 (1980). Absent an express exclusion, the requirements of §1395ww(b)(4)(A) must be applied in determining the PPS target amount as defined in §1395ww(b)(3)(A) and §1395ww(d)(1)(A). If Congress had truly intended for the PPS target amount and resulting hospital-specific portion to be calculated also "without application of subparagraph (b)(4)(A)" — the TEFRA adjustment — it would have said so. Like the Third Circuit in *Sacred Heart*, the court below simply glossed over this central principle of statutory construction. Indeed, the Court below did not even mention the fact that §1395ww(d)(1)(A) specifically excluded §1395ww(a) in deferring to the Secretary's current interpretation.

Congress' clear expectation that the Secretary take steps necessary to eliminate any identifiable and quantifiable "mismatches" between pre and post allowable costs in setting the HSP is also underscored by the Conference Report attending the PPS amendment, which states:

> The managers note that during the phase-in period, some portion of the prospective payment rate will be related to each hospital's own experience in a base-cost reporting year. *The managers recognize that, in some cases, the Secretary will have to use estimates to adjust some portions of the hospital's base-year experience to make it comparable to inpatient operating costs that will be paid under the prospective system — e.g.*, FICA

> taxes that would have been paid if the hospital had been in the social security system or the adjustment needed to exclude the nursing differential which is no longer payable. *Since the hospital specific portion of the rate must be determined in advance of the hospital's first fiscal year under the system, the managers expect the Secretary will use the best data available at the time to determine operating costs* for purposes of the phase-in. (Emphasis added.)

H.R. Conf. Rep. No. 98-47, 98th Cong. 1st Sess. 182, *reprinted in* 1983 U.S.C.C.A.N 404, 471-72. Similarly, the Senate Committee recognized that various "exceptions and adjustments" were appropriate to take such situations into account in that "the prospective payment is intended to be *payment in full for all covered items and non-physician services to hospital inpatients* (emphasis added)." S. Rep. 98-23 at 49, 50, U.S.C.C.A.N. at 189, 190. This legislative history is consistent with, and, indeed, unmistakenly confirms Congress' expectation that the TEFRA base-year cost adjustments were to be made by the Secretary in setting the HSP.[18] These reports were ignored by the Court below.

The lower court erroneously concluded that incorporating subsection (b)(4)(A) would have been redundant because of the fact that one PPS provision, 42 U.S.C. §1395ww(d)(5), separately and independently affords the Secretary discretion to recognize exceptions and adjustments under PPS. (App. 7a) To the contrary, 42 U.S.C. §1395ww(d)(5)(A)-(H) authorizes certain specific adjustments and exceptions for certain classes of hospitals and cases throughout the course of PPS (e.g., special rules for extraordinarily lengthy hospital stays; reimbursement of sole community

18. In recent cases involving this issue, the Secretary has disingenuously cited in isolation a statement in a Committee Report that a hospital's target amount under PPS would be adopted "without regard to the exemptions, exceptions and adjustments which may have been authorized under TEFRA for that year." H.R. Rep. No. 98-25, 98th Cong., 1st Sess. 132, 136, *reprinted in* 1983 U.S.C.C.A.N. at 355. This quotation is totally misleading. It refers to a version of the bill H.R. 1900, Rep. No. 98-25, Part I, 98th Cong. 1st Sess. that was never enacted. The reference therein was to a distinct set of exceptions to rates determined using TEFRA percentage limits (found in §1395ww(a)(2)) which were *not* included in the target amount setting formulation ultimately adopted by the Conference Committee. The reference to these particular exemptions, exceptions and adjustments thus became moot. As to the final version actually enacted by Congress, the statement in the Conference Report expressly recognizes the need to make "adjustments" to the target amount ultimately selected for setting the HSP.

hospitals). 42 U.S.C. §1395ww(d)(5)(I) gives the Secretary general discretionary authority to provide for other exceptions and adjustments "as the Secretary deems appropriate." Subsection (b)(4)(A), on the other hand, distinctly deals only with setting *hospital-specific target amounts* for the transition period. Adjustments to the target amount were *mandated* where the conditions delineated in that subsection, i.e., certain types of events or circumstances which distort the comparability of base-year operating costs, are met. Subsection (d)(5)(I) is a far broader "catch-all," providing for all manner of discretionary exceptions which the Secretary might decide to adopt in applying DRG payments to PPS hospitals. These provisions are thus readily reconciled.

Finally, the lower court noted (App. 6a) that:

> [S]ubsection (b)(4)(A) explicitly authorizes the Secretary to depart from the 'target amount' benchmark in (b)(3)(A) in specific circumstances, suggesting that incorporation of (b)(4)(A) might conflict with the congressional intent partially to base reimbursement on the target amount during the PPS transition period.

This point is a red herring. The only provision of subsection (b)(A)(4) to which the Court could be referring (since none is identified) concerns the assignment of a new base period which is more representative of the reasonable and necessary costs that a hospital incurs after its base year for TEFRA cost limit purposes.[19] What the Court apparently did not recognize is that subsection (b)(4)(A) was amended to permit the assignment of a new base year for PPS-exempt hospitals by the Omnibus Budget Reconciliation Act of 1989, §§6015(a) and (b), well after the expiration of the transition period relevant to this appeal. Thus, the provision which apparently caused the Court concern is totally irrelevant to analysis of subsection (d)(1)(A).

---

19. *See* n. 4, *supra*.

III. THE DECISION BELOW MISAPPLIES CHEVRON AND ITS PROGENY AND ENDORSES A STANDARD OF REVIEW THAT FRUSTRATES CONGRESSIONAL INTENT

The lower court has construed the standards for statutory construction in a manner which gives regulatory agencies wide rein to frustrate clearly expressed congressional intent. The decision below not only ignores what most courts have found to be an obvious legislative mandate, it affords controlling significance to an agency litigation position that is plainly at odds with the Secretary's contemporaneous construction of the Act and represents a clear flip-flop from the view enunciated contemporaneously when the statutory machinery was being put into motion. *See Udall v. Tallman*, 380 U.S. 1, 16 (1985).

A. This Court's decision in *Chevron, U.S.A. Inc. v. Natural Resources Defense Council, Inc.*, 467 U.S. 837 (1984), provides the proper framework in which to review an agency's construction of a statute:

> First, always, is the question whether Congress has directly spoken to the precise question at issue. If the intent of Congress is clear, that is the end of the matter; for the Court, as well as the agency, must give effect to the unambiguously expressed intent of Congress . . . . [However,] if the statute is silent or ambiguous with respect to the specific issue, the question for the court is whether the agency's answer is based on a permissible construction of the statute.

Id. 467 U.S. at 842-43. "The traditional deference courts pay to agency interpretation is not to be applied to alter the clearly expressed intent of Congress." *Board of Governors of the Federal Reserve System v. Dimension Financial Corp.*, 474 U.S. 361, 368 (1986). A reviewing court must reject the Secretary's statutory construction if it is "inconsistent with the statutory mandate or . . . frustrate[s] the policy that Congress sought to implement." *Securities Industry Ass'n v. Board of Governors of the Federal Reserve System*, 468 U.S. 137, 143 (1984), *citing FEC v. Democratic Senatorial Campaign Committee*, 454 U.S. 27, 32 (1981).

In ascertaining the plain meaning of a statute, the judicial inquiry must encompass both the particular statutory language and the broader design of the statute. *K Mart Corp. v. Cartier, Inc.*, 486 U.S. 281, 291 (1988). Moreover, in determining whether

the Secretary's approach is consistent with that of Congress, a reviewing court must look to both the statute and the legislative history. *Chevron* at 842-43; *Georgetown* at 326, 328; *Washington Hospital Center* at 143, 148-49; *New York City Health and Hospitals Corp. v. Parales*, 954 F.2d 854, 858 (2d Cir.), *cert. denied*, ___ U.S. ___, 113 S.Ct. 461 (1992). The court below inexplicably ignored the pivotal pronouncement of the Conference Committee (pp. 14-15, *supra*; emphasis added) that the Secretary "*will have to*" affect adjustments fitting the precise description of the TEFRA adjustment provisions, i.e., to "make it [the hospital's base-year experience] *comparable to inpatient operating costs that will be paid under PPS*" in setting the hospital-specific rate under PPS. In failing to even consider the legislative history of the PPS statute, the Circuit Court violated a fundamental precept of the *Chevron* doctrine.

Congress spoke "directly to the precise question at issue in the instant case." As shown above, the requirement to eliminate distorting mismatches in pre and post-base year allowable costs attributable to coverage changes beyond the providers' control is explicit under the statute, and directly reinforced in the legislative history. Congress clearly intended to slowly wean hospitals from the cost reimbursement system by only gradually divorcing their payments from a hospital-specific cost approach. Of necessity, the HSP component incorporated into the prospectively applied transition period rate had to be fixed in advance. But Congress intended the target amount to represent as close a proxy as reasonably possible to actual allowable hospital-specific costs that would be incurred during the transition period. Failing to adjust a hospital's base-year costs in accordance with Section 1395ww(b)(4)(A) collides with the plain design of the Medicare Act, and frustrates Congress' plainly expressed intent to eliminate significant distortions between base-year costs and PPS rate-year costs during the limited duration of the transition period.

B. Every district court, and every court to consider the issue until *Sacred Heart Medical Center v. Sullivan*, has held that the statute, taken in the context, clearly indicates Congress' intent to incorporate the TEFRA adjustments into PPS. None of these courts even reached the second step of a *Chevron* inquiry, *i.e.*, the reasonableness of the agency's interpretation. Assuming *arguendo* that a court could find that the congressional intent was

not manifest, the Secretary's current interpretation of subsection (d)(1)(A) would be due no deference because it (1) represents a totally unexplicated about-face from the Secretary's contemporaneous interpretation and application of subsection (d)(1)(A), and (2) is a litigation position which constitutes nothing more than a *post-hoc* rationalization.

Deference to the Secretary in these circumstances is flatly contrary to this Court's instruction that no deference is due to an agency position which amounts to an unexplicated reversal of field or the *post-hoc* rationalization of counsel. *Motor Vehicle Manufacturers Ass'n v. State Farm Auto Ins. Co.*, 463 U.S. 29, 43 (1983). *See also Bowen v. Georgetown University Hospital*, 488 U.S. 204, 212-13 (1988); *Securities Industry Ass'n*, 468 U.S. at 143-44. Deference in these circumstances is also counter to this Court's reasoning concerning varying agency interpretation of law in *Good Samaritan Hospital v. Shalala*, ___ U.S. ___, 113 S.Ct. 2151 (1993), the import of which should be further clarified on review of the instant case.

Although this was not even alluded to in the lower court's analysis of subsection (d)(1)(A), the preamble to the Secretary's final regulations implementing PPS states unequivocally that:

> We believe that Congress intended to assure, by giving us broad authority under the law to provide for exceptions, exclusions and adjustments, that some hospitals are not advantaged or disadvantaged by unique circumstances in their base year that do not reflect their usual cost of operation per case. *This intent is indicated in Section 1886(b)(4)(A) of the Act* (emphasis added).

49 Fed. Reg. at 261 (Jan. 3, 1984). Thus, at the outset of PPS, the *Secretary* pronounced that the TEFRA adjustment provisions of subsection (b)(4)(A) applied in calculations of the hospital-specific portion of the PPS rate.[20]

In the *Greenville, supra*, litigation, which took place within a year of that publication, the Secretary agreed to make adjustments to the HSP based on the standards of subsection (b)(4)(A)

20. This conclusion was later reiterated in a notice of proposed rulemaking published in 1986. 51 Fed. Reg. 8208, 8210 (Mar. 10, 1986). That proposed rule contained a "clarification" of policy which indicated that §1395ww(b)(4)(A) provided authority for adjusting the HSP by proposing to expressly incorporate the TEFRA regulations (42 C.F.R. §405.463 (1985), subsequently redesignated 42 C.F.R. §413.40) into PPS. The proposed rule, however, purported to permit

for purposes not specifically listed in 42 C.F.R. §§412.71 and 412.72. When the instant case was originally brought before the District Court, the Secretary, although making token statements to the contrary, assumed *arguendo* that the TEFRA standard applied under PPS, specifically directing that court's attention to the decision in *Sunshine Health Systems v. Bowen*.[21] Indeed (and apparently unbeknownst to the Third Circuit), HHS *continued* to cite and apply the standards of subsection (b)(4)(A) in actual practice, granting "distortion"-eliminating adjustments after publication of the proposed rule in 1986. In a policy letter (which was evaluated in *Newport Hospital and Clinic v. Sullivan, supra*), Linda Magno, Director of the Health Care Financing Administration's Division of Hospital Payment Policy, expressly acknowledged the application of the TEFRA exception and adjustment clause to PPS.

The Secretary's position advanced before the appeals court in the instant case is thus inconsistent *inter alia* with the agency's position in *Chandler*, HHS's actions in the *Greenville* and *Newport* litigation, and with the official policy statement published when the PPS system was being implemented. As this Court recently held:

> the consistency of an agency's position is a factor in assessing the weight that position is due. As we have stated, "[a]n agency's interpretation of a relevant provision which conflicts with the agency's earlier interpretation is 'entitled to considerably less deference' than a consistently held view." *INS v. Cardoza-Fonesca*, 480 U.S. 421, 466 n. 30 (1987) (*quoting Watt v. Alaska*, 451 U.S. 259, 273 (1981)). How much weight should be given to the agency's views in such a situation.... will depend on the facts of individual cases. [*Id.* (citation omitted).]

---

only prospective adjustment of the HSP only for those years still remaining under transition period after the adjustment was approved; the rule was never adopted in final form, ostensibly because the D.C. Circuit thereafter held in *Georgetown* that challenges to base-year costs included in the HSP, if timely appealed, had to be made retroactive to the outset of the PPS transition period. Ironically, the Third Circuit in *Sacred Heart* misconstrued this unpublished proposal as a more recent agency interpretation of the statute disavowing the incorporation of subsection (b)(4)(A) adjustments under PPS.

21. In fact, in *Chandler*, counsel for the Secretary appears to have acknowledged that TEFRA adjustments are available under PPS but that regulations clarifying the procedures for requesting such adjustments have not been promulgated. 963 F.2d at 1214 n. 4.

Good Samaritan Hospital v. Shalala, 113 S.Ct. at 2161. The Secretary has not changed her position on the incorporation of the TEFRA provisions into PPS as a result of divergent or erroneous court decisions. Rather, she has reversed her position arbitrarily and for no apparent reason except to prevent having to pay hospitals additional sums of money.[22]

Absent a definitive ruling from this Court, the Secretary will be free to change her opinion on this issue depending upon the court in which HHS is proceeding. Such an ad-hoc approach has and will continue to result in certain hospitals being granted adjustments to their base year figures under 42 U.S.C. §1395ww(b)(4)(A) while others are denied the very same adjustments. Under a system designed to compensate Medicare providers on a uniform basis, such variations in reimbursement are unacceptable. This case presents an appropriate vehicle for refining the circumstances when agency vacillations deny deference to the agency's interpretations.

---

22. Although the Court of Appeals made conclusory statements to the contrary, there was absolutely *no* rational justification officially advanced by HHS, in regulations or otherwise, for her about-face here, and no explanation given for allowing fiscal intermediaries open discretion to effect only negative adjustments to base-year costs.

CONCLUSION

For the foregoing reasons, this Court should grant the petition and issue a writ of certiorari to the United States Court of Appeals for the District of Columbia Circuit.

Date: Philadelphia, Pennsylvania
September 16, 1993

Respectfully submitted,

WOLF, BLOCK, SCHORR and SOLIS-COHEN

/s/ MARK H. GALLANT

Mark H. Gallant
Counsel of Record

Ellen N. Berman

WOLF, BLOCK, SCHORR and SOLIS-COHEN
12th Floor, Packard Building
S.E. Corner 15th & Chestnut Streets
Philadelphia, PA 19102-2678
(215) 977-2000
Attorneys for Petitioners